Pyramid of Hope Counseling, LLC
5 W. Main, Ste. 3
Boyne City, MI 49712

Website: pyramidofhope.com
Main#: (231) 881-5001
Fax#: (231) 344-6100

Date: ___________

Health Information – Child (under 17)

Child's Name: ____
(First Name) (M.I.) (Last Name)

Address: ____
(Street and PO Box) (City) (State/Zip Code)

Date of Birth: ______________________ Age: __________

Parent/Guardians' Phone: (H) ____________ (Cell) ______________ (W)__________
P**lease circle the number(s) to use to contact you and if a message can be left at that number.**

Parent/Guardian's address if different from the child: ______________________________

____

Parent/Guardians' Email: ______________________May we contact you via email? Y/N

Physician's Name: ______________________________Phone: ______________

Physician's Address: ____

Date of Last Physical: ____
Current medications, dosages and reasons your child is taking them:
____

____

____

Emergency Contact Person(s): ______________________ (Phone): ______________
Relationship to the child: ______________________________

Has your child ever had thoughts of (or attempted) suicide that you know of? __________

Briefly describe the nature of your child's main problem(s) and how long they have been present:
____
____
____

Referral Source: ____